MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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COMMISSIONERS PRESENT:

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ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Report of expert panel on changes in medical practice and the delivery of care: Implications for the Medicare benefit package
-- Bob Hurley, Mathematica Policy Research; Helaine Fingold

MS. FINGOLD: Good morning, I'm here to introduce Dr. Marsha Gold and Dr. Bob Hurley, who we contracted with through Mathematica Policy Research. Dr. Gold and Dr. Hurley have helped us convene a panel to look at the context of changes in medical practice and delivery of care since the inception of program.

Staff thought we needed context in looking at the benefit package, not just to recount the types of advances that have happened in the interim, but really to look at changes in technology and delivery, how it's impacted beneficiaries, how they're treated, what kind of services they receive. We wanted to look at the whole picture and we help that would be helpful in assessing where the benefit package has been and where it may go in the future.

Dr. Hurley is going to walk through what happened at the panel, who was on the panel, give a summary. You should each have a written summary of the panel that Dr. Hurley prepared. We're sorry we couldn't get it to you earlier. The panel was only a week ago and we actually turned it around fairly quickly, and we thank them for that. It's still in draft, but I don't foresee that it's going to have major changes made to it.

So I will allow Dr. Hurley to proceed, and Dr. Gold will be presenting subsequently. David Glass will be here to describe that project afterwards.

DR. HURLEY: Thank you and good morning. This was an expert panel that was held, as Helaine said, last Wednesday, I believe it was. Marsha and I have done about a dozen of these over several years for both this commission and for PPRC. She has moderated this panel and I prepared the summary and the report.

Because of the short time frame you have only a draft summary, but I think it gives you a fairly good depth of what was covered in the session. So let me take you through the key points and highlights, if I might.

The panel membership, you just heard a bit about them. The panel included a very diverse group of people with expertise in chronic care management, geriatrics, technology assessment, epidemiology, ethics, managed care, integrated delivery systems, and Medicare policy. Further indication of its diversity was the fact that one of our panelists said he was caring for patients before Medicare was passed, and another panelist said he was born after Medicare was passed. So we covered the spectrum pretty nicely.

The focus of the discussion was on four broad areas: changes in care delivery and clinical practice, the implications of these changes for the Medicare beneficiary population, gaps in current Medicare benefits and you'll see also related to some payment issues, and then advice for improving the Medicare benefit package. So we'll talk about each of these four areas in a little bit of detail right now.

Obviously, the panel was very direct about the range of expanded diagnostic and treatment possibilities that have occurred, given advances in medical science and technology. And they highlighted the fact that the changes have occurred not only in terms of the range of interventions, but also the pace of interventions which has significant implications for providers, for patients, and for the social systems of these patients.

Also, they talked about the fact and related to the fact that many of these technological developments have not been consistently subjected to cost-benefit and cost-effectiveness analyses. They also reflected a disproportionate interest in emphasis upon acute care and suggested that that competes with the management of chronic illness, which may not benefit the many beneficiaries who do not benefit from those.

In addition, they commented on interest an emphasis on prevention continues to lag the developments in terms of acute care. And that again has significant implications, as we'll see in a moment.

The second broad area they spoke to was the changes in the rising patient needs and patient expectations. Again, part of this was a function of the success of acute care, in terms of prolonging life and, in many cases, improving life. But also, leading to more people living with chronic conditions.

They also emphasized the importance of rising patient expectations that have accompanied these changes in the sense that patients, and in many cases their physicians, are operating under the assumption that any condition can be treated if patients and physicians persist in seeking those treatments, making it difficult to distinguish between what's valuable and what's futile.

Growth in medical and health-related information also was addressed in this area, in terms of how much more patients know and also, to some extent, how much more they're misinformed, which has significant implications for the amount of time that their clinicians are having to spend with their patients, in terms of education engaging them and understanding these issues.

On a more positive side, this has had an empowering effect for patients in improving their ability to be engaged in the care delivery process.

In addition to these issues about information, there was also a sense that racial and ethnic diversity is confounding the ability of providers to be able to uniformly communicate with their patients.

Broader social and demographic trends have altered social systems in important ways that are particularly pertinent in terms of persons who have disability or chronic disease and have need for these support systems to keep them in independence.

A third broad area that was highlighted was the role and the importance of team-based care delivery. As one of the panelists characterized it, the prototype of the physician as captain of the team is giving way to the notion of medicine as a team sport. And so consequently, the role of the team-based delivery has become much more prominent and has altered the relative importance of the various participants on the clinical teams.

The degree to which teams are actually formally structured and managed and organized varies greatly by settings, and there's a sense that this is an area which will have to see more improvement in order to really benefit from the full fruition of team-based care.

But panelists pointed out particularly an important irony that the ability to move in the direction and to accommodate the pressure to move toward team-based care delivery faces a significant impediment because of the centrality of the one-to-one patient/physician relationship which patients continue to assign enormous value -- some panelists felt disproportionate value in light of the fact that in many cases individual physicians are overmatched by the demands upon them at this point in time.]

A fourth area is limited exploitation, concern about limited exploitation of information technology and decision support possibilities. The panelists remarked on the revolutions that have occurred in communications and information technology that have accompanied the medical science and technology changes that have occurred, but they noted there's a significant gap in the application of information technology and health care, particularly given relative to what is actually technically possible.

They attributed this slow and uneven pace of the adoption of technology to under investment, lack of resources for investment, lack of incentives for investment, and structural impediments among providers and patients to more ambitious adoption of information technology. They suggested that this is an area where some of the most important advances in care management will come in the future of these impediments can be overcome.

The fifth point was, in some respects, a reconsideration of the preceding four, in which the panelists expressed the view that in many respects delivery systems, in particular, have not fundamentally changed over this period of time, partly because of the centrality of the physician/patient relationship. Also, because of the ability to achieve the clinical integration that many have suggested would be coming, the inability to actually employ more successfully administrative technology which exists but is not applied in the health care arena.

Now if we go to the next slide, we'll talk specifically and derive some implications for Medicare that were highlighted. I think one of the panelists said virtually everything that I just described to you is intensified in the Medicare population. We have a program that has a very strong acute care orientation. And in the minds of the panelists, Medicare has generally kept pace well with advances in clinical diagnosis and treatment, particularly with respect to new technologies with the very notable exception of outpatient pharmaceutical benefits.

On the other hand, Medicare -- like the acute care system as a whole -- undervalues and under invests in preventive care. That is compounded by the late onset of eligibility for the program.

While it has been a bona fide innovator and standard setter in payment methodologies for hospitals and physicians and post-acute care, its methods have remained, however, largely focused on process rather than outcomes, rewarding effort rather than consequences.

The second point, in terms of the distinctive needs and subsets of the Medicare population, if I might just say a little bit about each of these bullets because this is important for some of the subsequent comments that we heard.

One of the panelists raised a distinction or suggested there were three broad subpopulations of Medicare, from his vantage point. There are the healthy Medicare beneficiaries with occasional acute needs and routine maintenance needs. The second subpopulation are the seriously ill with multiple chronic conditions, dependency, and at risk of further deterioration. And the third population are those who are severely ill, perhaps terminally ill, and have end-of-life care needs.

They drew this distinction by suggesting that, in fact, the person population is well-served by the Medicare program, with the exception of the outpatient drug benefit. The third population is also reasonably well served because of the hospice benefit. But the middle group, the seriously ill with multiple chronic conditions, dependency and at risk of further deterioration, is less well-served. That distinction is an important one, in terms of some of the recommendations you'll see in a moment.

A third point, in terms of the implications for Medicare, and this is the mirror image of the team-based care delivery, is a sense that Medicare has failed to actually develop a care coordination and case management compensation strategy. This care is particularly important for this second population that I was describing a few moments ago, and is also consistent with most prominent models of chronic care that case management and care coordination are central functions that have to be performed in order to provide care effectively.

There is a sense that Medicare's payment systems are simply out of sync with paying for coordinated care and consequently, by not paying for this care, is relying on this care to be delivered for free, if you will, or as a byproduct of the service delivery process thus extracting from providers a kind of forced contribution to make sure that that care is, in fact, being rendered for those patients who are in need of it, even though it isn't being paid for.

A larger concern among the panelists was that adding something only like care coordination in isolation could possibly be inflationary, because it would mean additional vendors and additional payment schedules and so forth. And there was a suggestion that there needs to be more serious consideration to sophisticated approaches to paying for disease management and ideally basing these payments on some kind of an outcomes basis rather than effort or process.

A fourth issue in relation to Medicare, to follow on the previous comments, a limited exploitation of information technology, there was a sense that Medicare payments and policies have not encouraged long-term thinking and planning for information technology investment. Patients are being seen by providers today who lack the requisite information sets to render care at the highest possible quality.

In addition, there are deficiencies in the application of available technology that's been linked to medical errors. So consequently, there is sound evidence to support the benefits and the gains from further investment in this area.

The last point in this regard, in terms of

Medicare implications, was a sense that there has been an underdevelopment of systems of care for the Medicare population, again something that flows from several of these earlier points. This was a pervasive theme. Particularly in light of the disappointment and experience in terms of the Medicare+Choice, the marginal scale of the PACE and the Social HMO programs, and the limited number of new coordinated care demonstrations. All of these indicate that most of the care for these chronically ill are still being paid in conventional methods.

If I could go to the next slide, I'll give you two slides here in terms of the identified gaps in benefits and then payment issues that are influencing or related to the gaps in benefits as identified by the panel. The first one obviously is outpatient prescription drugs. There was a complete consensus among the panel that this is the first priority and such an omission would be inconceivable if the Medicare program were being initiated today.

The physicians on the panel spoke to the fact that in many respects the absence of this benefit is not necessarily changing prescribing habits, it's changing patient compliance habit with the likelihood of actually getting the prescriptions and then using the prescriptions that the physicians have prescribed.

At the same time the panelists endorsed this strongly, they also suggested that the benefit must be carefully crafted and thoughtfully implemented to ensure that it is not exploited and that its contribution is not diminished. By this they meant that safeguards have to be put in place to promote appropriate use, careful monitoring of prescription and consumption habits, systematic evaluation of new products, and concerted efforts to educate consumers.

In fact, the ethicist on our panel suggested that the drug benefit might be a particularly useful opportunity to cultivate a sense of the commonly situated circumstance for Medicare beneficiaries to be sensitive to the fact that appropriate use is necessary to ensure this benefit is available to the most persons possible.

A second point, in terms of benefits, was care coordination and case management. Specifically, the importance of this benefit has already been identified. It's noted as particularly important for beneficiaries with multiple health problems, cognitive deficits and/or limited social supports. So this is too critical a service to be financed simply by cost shifting and cross-subsidization, as it currently is.

There was on the panel some concerns about the woodwork effect associated with covering a service like this that previously has not been paid for, but the panelists felt that this was worth the risk as long as the benefit was carefully crafted and designed and implemented.

They also suggested that they believe that these care coordination services are unlikely to produce savings but they will improve quality because of substantial unmet need in this area.

The next item on here was the package of enriched benefits for complex chronic illness care. An idea supported by several of the panelists was the program should consider developing something that's analogous to the hospice benefit that would be targeted to Medicare beneficiaries who meet certain screening criteria in terms of their being at risk for deterioration, the need for maintenance services, and the need for a care coordination strategy that would involve intensive multi-faceted intervention that could be funded in a way to forestall decline and debilitation.

Again, the issue of woodwork effects came up in this same discussion in the potential for gaming a benefit like this. But the panelists felt that a carefully developed screening criteria, perhaps looking at functional status and so forth as a basis for criteria, would be effective.

Another item here was preventive benefits enhancement, and just let me call your attention to it. It's not captured entirely in the bullet that I have up there. The preventive benefit expansion and coverage that was discussed was actually extending preventive coverages to the below 65 age, where there was interest, in fact, in terms of exploiting available information about where early intervention can, in fact, be effective. And as a consequence of that, the Medicare program would encourage investment in preemptive, if you will, as well as preventive services or secondary prevention kinds of interventions.

The idea here would be that ultimately these are persons who, when they become eligible, will have to be consuming substantial amounts of services and so we should use the best available knowledge to try to forestall and to prevent the occurrence of those conditions.

Another item that was identified, in terms of gaps of benefits, was mental health benefit improvement. This was largely devoted to two specific issues. One of them was the lack of availability of outpatient prescription drug coverage, which is so central for the management of chronic mental illness.

The second was, in some respects, a payment issue, whether or not psychiatrists are adequately compensated at this point in time in a way that Medicare beneficiaries have access to them. This what was behind that suggestion.

The final point was expanding cost-benefit and cost-effectiveness scrutiny of the benefits that are already in the program, and those that may be advanced. Part of this was because the non-linear nature in which new benefits are actually being developed and non-sequential decisionmaking that occurs. The consequence of that is that there are conscious trade-offs that are not occurring because the program is being drawn along by the coverage of high-tech services, perhaps at the expense of more personal kinds of care.

We have just a few items here under payment issues and structures that were also related to the issue of benefits package. They're not really payment policies as much as facilitated of the provision of these benefits. Payment methodology for care coordination. Recognizing that this will be a challenge to be able to develop this, the panelists felt that Medicare has an admirable track record in terms of payment innovation and this is one in which some ingenuity will be necessary to ensure that this doesn't lead to proliferation of simply new providers or more fragmentation in the system.

A second point was the payment for non-physicians, which had its roots in the issue of team-based delivery. There was a sense that Medicare is not as flexible in this as it could be. It also, through physician-centered payment, imposes significant accommodations to be able to assure that both the appropriate person is being paid to provide services and that the physician is in compliance with whatever the extant payment policies are.

Payment for information infrastructure to encourage investment was another area for consideration, in terms of the fact that current methods do not adequately target payments and encourage longer-term investments to fully exploit the possibilities in terms of information technology.

A fourth item in this area was that performance-based compensation, again there was a sense that if desirable to move in the direction of fee-for-outcome versus fee-for-service, at the same time recognizing that there are very significant impediments and technical problems to be able to achieve that. But there was a feeling that more could be done, given the progress that is occurring in terms of outcomes measurement, risk adjustment, the understanding of behavioral dynamics of incentives and related issues.

Counterbalancing this argument, however, was some sense among panelists that the political context of Medicare may not permit quality or outcome-based differential payments, in terms of whether or not the program could, in fact, engineer and implement something like that.

The last item on here, in terms of payments and incentives, at system level structure and performance again was reflecting this issue that we have not seen fundamental change and we have not developed successful models, perhaps sustainable models, for systems of care. They cited the IOM's Quality Chasm Report of identifying clear criteria that are associated with successful systems of care, and the idea of possibly incorporating that into payment methods would be worth exploration.

My last two slides are really kind of the rapid fire closing round of issues of when Marsha asked the panel to identify what would be the priorities they'd recommend to the Commission and to Congress, they went through many of these same things. But let me just quickly go through them and see if there's any we didn't cover.

Covering outpatient drugs quickly but wisely. Adding a care coordination benefit, perhaps as part of a package of services for the seriously, chronically ill as we talked about a moment ago. Devote greater attention to cost-benefit, cost-effectiveness evaluation of current and future benefits. Consider how a transition from process to outcome-based payment methods might be engineered. Build more flexibility into the program designed for future adaptation. Again, the sense of the panelists was that the Medicare program needs to be thinking about itself 30 years from now, just as its been through the first 35 years. So as we think about genomics and so forth, those kind of emergent areas, the idea of building some kind of a foundation to accommodate those seems important.

Devote more attention to provider and neutral payments, which again was the notion of considering other potential providers of services as qualifying for payment. Avoiding increasing beneficiary copayments as the burden falls most heavily on the sickest. This again was voiced by several of the panel members. Assess the feasibility of coverage for preventive benefits beyond the normal Medicare program boundaries, as I mentioned a moment ago.

Incorporate federal prevention guidelines into benefit and payment designs. The fact that those exist now and have been accepted is a basis for more forthright incorporation into payment methods.

And the last two were more general and sweeping suggestions. Evaluate the implications of national versus local coverage decisions on technology adoption and use. Again, some of the technology assessment folks on the committee raised that issue.

And the final point was the promotion of more use of demonstration authority to encourage innovation, but don't limit the program simply to demonstrations for the purpose of finding and embracing new innovation.

The last slide, if I could, is just a summary slide that highlights three key points. Medicare, like our health system as a whole, remains strongly oriented toward acute care in the minds of the panelists. That is certainly emblematic of the program. They felt that Medicare has kept pace well on technology adoption, except for the notable deficiency in outpatient pharmacy benefits. And the benefit improvements are most necessary for beneficiaries with serious chronic conditions and multiple service needs.

DR. GOLD: If I can add one thing briefly, before we start, one thing you see running through the panel meeting, if I can step back, is we put together the agenda and it focused directly on what your report is and benefits and what we should do.

What was interesting, and we had some give and take with the panelists about this, was to what extent you could distinguish benefit decisions from payment decisions from organizational decisions. The issue being they understood that, but maybe as you're thinking about this, how much of it is paying for each service versus putting them together.

And then the other side of it, which is the dilemma, I think, for the Commission is how much Medicare and Congress can push ahead of where the rest of the health care system already is and to what extent you can assume that certain things would change. But I think a message coming out of what they say is even though you're focused on benefits, and we tried to keep pushing them back there, they kept pushing back because they saw some of these things as not unrelated, I think something which probably gave Murray a headache.

DR. NEWHOUSE: Thank you for doing this. I have several questions, let me just ask some about the recommendations on paying for coordination and paying on outcomes. On coordination, did the issue come up of how one would verify effort? And what this would mean operationally?

DR. HURLEY: No, we didn't get to that level of detail. I guess I could have said one of the specific suggestions was the idea of possibly paying a retainer of some kind. That was about the most specific suggestion I think we heard with respect to care coordination methodologies.

DR. NEWHOUSE: I suggest there still is an issue about what it is you're buying and how you can tell that you've bought it.

On outcomes, this may have been what you meant by the organization and delivery, but did the panel talk about who was responsible for outcomes in the context of traditional Medicare? That is, if a patient with a chronic problem is seeing multiple physicians and there's going to be some variation in payment based on what happens with this patient, who takes the variation?

DR. HURLEY: The attribution issue didn't come up at all, in terms of responsibility for care.

DR. NEWHOUSE: Did they get to the point about whether the outcomes they mainly had in mind were prevention of acute events or outcomes conditional on the events? Did they have both in mind?

DR. HURLEY: I think some panelists had both of them in mind. Certainly, there was a significant amount of discussion within the panel itself about the degree of difficulty associated with moving in this direction, certainly. They were not naive about this, I think we can say.

DR. NEWHOUSE: That brings me to my last question, for the moment anyway. Did they talk about the selection issue at either level? That is, if I'm paying on whether the event occurs, I'm going to be not so interested in people's whose lifestyle is not so great. And if I'm paying on improvement conditional on event, I'm not going to be so interested in the non-compliant patients?

DR. HURLEY: Absolutely, yes. We had a couple of clinicians who were actually still seeing patients. In fact, that was the point they said. If you went to a base versus bonus payment, we would probably just get the base because we get the sickest people. I think there was real sensitivity about the degree of difficulty of that.

DR. ROWE: Let me echo Joe's gratitude to you, for being our guest lecturer, one of our guest lecturers, and for putting together this panel. I know some of these people and think they're very able, very interesting mix of experiences.

I have a couple of points. One of them is really just for the record. I think it's self-evident to everyone here, and it certainly was to you. But if you look at your gaps in benefits, outpatient prescription drugs, case management care coordination, preventive benefits enhancement, mental health benefit. If we could develop such a program like that with health plans we might call it Medicare+Choice.

DR. HURLEY: We thought of that actually.

DR. ROWE: Just an idea. I don't know whether it came up in your discussions at all.

DR. REISCHAUER: It doesn't seem to be working, though.

DR. ROWE: Was there any discussion about that?

DR. HURLEY: Yes, there was. In fact, when we talked about systems in care, and I think I mentioned this simply in passing, that there was a sense that the disappointing experience with the coordinated care program under Medicare+Choice, as well as some of the other small-scale demonstrations, have demonstrated the capability of doing this but they've been troubled in terms of their stability and sustainability.

DR. ROWE: But there is this grand experiment here.

DR. HURLEY: Yes.

DR. ROWE: I have maybe four questions for you. I'll just read them off and you can respond, either you or Marsha can respond to these, or not at all

One is I was struck by the absence of the word quality in any of your slides or in anything that you said. I wondered whether or not the recent reports from the IOM came up? Whether or not your panel was concerned about whether this beneficiary population was disproportionately at risk for errors, safety issues, et cetera? How they felt about the general quality?

Secondly, with respect to access, you mentioned that access for the first population seemed to be pretty good, general needs. And that access to the end-of-life population seemed good because of the hospice benefit, which I was surprised to hear because I think we've seem some data that while that may be increasing, it's rather heterogenous in its use, et cetera, although use recently is improved in minority populations.

I'd be interested in whether there was any discussion of access with respect to that.

You also seemed to suggest that access was limited for the seriously ill population and I just want to clarify that, that that's the case.

The third question has to do with prevention. Mae pointed out the discordance or dissonance between the U.S. Task Force on Preventive Services recommendations and Medicare's current coverage policies. I think you mentioned with respect to bone density screening and PSA on the one hand of things that Medicare pays for that aren't recommended. And then there are things such as smoking cessation and other things that maybe are recommended that Medicare doesn't. I wonder whether you had any discussion about, your panel had any recommendations with respect to the concordance or lack of concordance of those and what direction we should go in?

And I guess the last question I had was that the only priority that I heard you say was that everyone seemed to agree that the highest priority was an outpatient prescription drug benefit. Stipulating that, I wondered whether or not beyond that whether there was any discussion amongst and between the panel members with respect to the relative priority of some of these other recommendations that are being made, all which would, of course, equaled the national GDP here.

Can you give us any guidance beyond the outpatient prescription drug benefit with respect to where they felt the greatest opportunities were to enhance the program? Thank you very much.

DR. HURLEY: Let me go back, your first question had to do with the quality issue, and indeed there was discussion of quality, although I guess we wouldn't say it was a featured issue. There was several invocations of the IOM's report. And as I suggested earlier, some of the thinking that system level payments could, in fact, foster adherence to some of the recommendations of the IOM report in a way that they haven't necessarily done to date.

Also, the issue associated with outcomes-based payment systems and methodologies was that those outcomes bases would, in fact, include quality indicators and metrics for inclusion in those payment methods. Although, that's where I suggest that some panelists were concerned about whether differential payment methods, in fact, would be permissible that, in fact, implied that there was variation in quality on which payment was forthcoming.

With respect to access, I think the idea -- we did not talk very much about the hospice benefit, as I recall. But let me just say a couple of things and then Marsha can fill in this. I think the hospice was characterized as the kind of package of benefits that is existing that would be analogous to what another package of benefits might be developed targeted toward that second group.

There wasn't a discussion about the accessibility or the utilization of hospice in this discussion.

And then the third issue about the seriously ill, I think the point, if I implied that there was concern about access, the implication was that the care that they're receiving is not adequately compensated in the sense that it requires the care coordination that's now being rendered by providers is actually contributed care by those providers because it isn't separately paid. And so it's dependant upon the willingness of the providers to make this available.

There was a suggestion that because of the apparent decline of cost-shifting and cross-subsidization capabilities in the delivery system, this care might be at risk.

DR. GOLD: On that second question, before Bob goes on to the others, on the hospice one, there were I think a number of practitioners who talked about the problem of people not wanting to either admit that they're dying or deal with that, and that was a barrier to using the benefit because it's a six month period. And also, a concern that you had to make a decision, palliative care or. And so there were some issues, I think, that came up in the panel where the end of life issues were there.

I think the main point, though, was just because of the acute care focus of the benefit package, it does a better job of dealing with people who have episodic needs rather than that middle chronically ill population. And so that was really where it came in. It wasn't that there weren't things that could be improved for the people who were terminally ill.

DR. HURLEY: The other two points you mentioned, on prevention we had a limited discussion of the value and the importance of adopting existing prevention guidelines in the Medicare program. I believe that's as specific as we got. We never got to the level that you were raising.

And your last point was other priorities. I think the second priority on my list here was adding a care coordination case management benefit was the other one that was a fairly close second. Beyond that, we actually began to see them spread out. And you can see on this list, some of these are quite general without the same sort of benefit.

DR. ROWE: So that beat out prevention?

DR. HURLEY: Yes, indeed.

DR. ROWE: That's interesting. That's very helpful, Bob. Thank you very much.

MS. ROSENBLATT: My question is on information technology. It sounds like since it's coming up with payment issues, there's almost a thought of paying individual providers for the information technology. And it would seem to me that a lot of what we're talking about does require some kind of huge system to collect enough data to see what's really going on.

So could you elaborate on that?

DR. HURLEY: I think there are two questions here, or that there are two issues that fit together, I believe. One of them was the information technology possibilities that exist to actually provide the term decision support systems for health care providers, particularly physicians. They're there but they're not actually being implemented to the degree possible because of difficulties or reluctance to invest and to bring those systems up and put them in place.

Now whether or not individual practices or individual small groups of physicians are likely to be able to do that is another related issue. Part of the response to that was the belief that systems of care, in the broadest sense, organized delivery systems are going to be necessary in order to have those kinds of platforms in place in order to able to acquire the information technology and then put it in use in such a way that it actually supports the care that's being rendered by individual physician.

So there's really two levels to this. It's the fact that there's information technology that could contribute to better care, but in order to find a way in which there's an enterprise that can invest and develop those is the system of care concern.

MR. FEEZOR: First off, I found the categorization of the three populations within Medicare to be very helpful. And again, I think finding ways in a targeted fashion to sort of separate out what might be the needs and designing benefits to match that is very appropriate for us to give some further consideration to.

Second, I guess I'd like to underscore something I think I heard Marsha say right off the top. I think that we ought to at least put the question out. That is Medicare either is a change agent or, in fact, is a social security blanket -- no pun intended -- that automatically inherently sort of goes towards the status quo.

I say that, participating for instance in Pacific Business Group on Health, aggregate spending in health care in California and near areas is probably $8 billion. This sense of well, we can't move on some of the things because of the preponderant weight of government systems, and particularly Medicare.

So I think that question ought to be framed because I think our report will be coming out at a time where even the private sector has renewed question mark about whether we can sustain the current system and whether it needs to be deeply changed.

The final comment quickly, is talking about gaps. I think there is a gap in care coordination across the current payment systems. Our panelists were asked to look at Medicare by itself and yet, we know that, at least in California, about two-thirds of the retirees have, for instance, some form of pharmaceutical coverage.

I can tell you that I have tremendous exposure in terms of our Medicare supplemental products and lines, or Medicare+Choice. But I really don't have an incentive to take that on, in terms of care management or care coordination because I can't reach across that big barrier that separates Medicare.

Again, I know that it's getting into a touchy area of sort of private/public coordination, but I do think that's something that we need to frame. And I'm not alone. I've talked to other people in similar positions that just say I really would like to take on some care coordination and management and bring in some disease management to deal with my retiree population. But it really just isn't worth it, or I can't reach across to where so much of that is being paid.

DR. HURLEY: There were actually two points that were raised. Your comments remind me of two points. One was that the idea that actually Medicare should be looking at -- and the term that people used was transformational payment methodologies, which would be the kind of change agent beyond just simply static reimbursement methods.

On the other hand, there was an exchange early on in the discussion as to whether or not Medicare could, in fact, be perceived as a system financier or whether it's simply a payment vehicle. So both of those issues were present in the room.

DR. GOLD: We didn't really talk about, in the panel, the supplemental issues. They are critical. I know you have a session on it this afternoon. In other work I've done, I think it's a very important point and is worth thinking about.

MR. SMITH: Thanks, Glenn. And thank you, I found this very helpful.

I have two questions. One, Allen's just asked, I was interested in the question of coordination across payment systems.

But let me come back to Jack's point. I think many of us were struck, as you talked about gaps, about the correspondence between the gaps and what we had hoped to get out of health plans. I wonder if the panel had any conversation about how else would you do it? Where else in the system? What provider?

I know you talked, Bob, a little bit about the anxiety on the panel about creating a new benefit and a whole new layer of providers. But if not that, who? And where in the system might that care coordination be provided?

DR. HURLEY: There were a couple of responses. One of them was there was a little bit of discussion about packaged payments or bundled payments as another vehicle, another way of actually pulling together clusters of services or episodes of care, payment methods that actually would achieve some of that integrative activity but not necessarily do it at the health plan level, if you will.

The other point here, disease management. We actually did have a representative from the disease management industry participating in this. I think there was some sense that this issue of looking across, or sort of vertical strips of care, in fact is another means for looking at payment methods that actually would encourage linkage across and coordination of movement of patients across the continuum of care.

But I believe that's about as far as we went. I don't know if you recall anything else, Marsha, on that realm.

MS. RAPHAEL: To follow up on that, your last point was something that intrigued me, which is the main way of testing change right now in the Medicare program is through demonstrations. I think we would all agree that that is a very elongated, and not necessarily successful way, to promote and test innovation.

I was wondering if there was any discussion of any other ways to try to test different ways of either changing the benefit, targeting it differently, or testing different ways of delivering or financing the service?

DR. HURLEY: I don't think there was and, as I think I said at the end of my comments, that while there was interest in and desire for greater flexibility to stimulate more demonstrations and innovation, there was also a sense that it would be bad policy to rely solely upon demonstrations as a source of that innovation because of the protracted period in order to get things from this.

But that really wasn't within the field of vision for the panel.

DR. GOLD: I vaguely have a sense that there may have been some sort of discussion of examples where you could give flexibility to do things slightly differently if it would be better within the regular program. But I don't think it was an extensive part of the discussion, though I think the point is very consistent with the general concerns that the panelists talked about, about why are we doing all these benefits? I mean, ultimately what are we trying to achieve?

DR. HURLEY: I think probably the best example we had in the discussion really was the idea of preventive benefits to persons below the age of 65, so that actually you stretch the boundaries of eligibility, in some respects, based on the dictates of good science, as it were.

DR. NELSON: Was there discussion about what happens to pre-Medicare patients who are in disease management systems for diabetes or congestive heart failure or whatever when they suddenly hit the Medicare wall and they're no longer eligible? What do they do?

It seems to me that if I were a patient and very pleased with my progress in an existing private sector system and found out then that I couldn't continue to participate under the Medicare program, I'd be unhappy.

DR. HURLEY: That actually did not come up. Of course, it's a familiar concern with moving into a Medicare health plan, as well, if you're in a commercial plan that's not participating. But that did not come up in the discussion.

MR. MULLER: Brief question. Given the increased complexity of coordinating care over a lifetime, across diseases with all possible interventions, a lot of people in the under-65 population of increasingly using the patients as individuals as a coordinator of care. In the Medicare population, it's commonly hypothesized that that's just too difficult to do.

As you look at those three populations that have been identified, is it possible to consider at least the first population as a group that might be more involved in the coordination of the care? Or is it unlikely that we could consider the population as a whole as one where the individual becomes a coordinator of care?

DR. HURLEY: I think that the sense that part of the differentiation among the three groups was that that first group was, in fact, capable of and was much more like the privately insured population, who is increasingly empowered by more information and more actively engaged in the care management process.

Whereas for the other populations, both the hospice -- although, again end-of-life care is another form of empowerment perhaps -- the other population was the one in which a surrogate for care management, care coordination was seen as necessary to really offset the deficit that those patients might, in fact, be experiencing.

MR. HACKBARTH: Okay, thank you.

A theme that I've heard here, that I would like to see included in the report, is that there are inextricable links between benefits and system design and payment methods and performance measurement. That is, I think, pretty obvious. But I don't think it can be said often enough.

When you write a report that has benefits somewhere on the cover, I think we have to early and often remind people how linked these things are. And I think it makes it very challenging to think about reforming the Medicare benefit package, because there's so many variables that need to come together to make it work to actually improve care. Just a theme for inclusion.